

Letter to the Editor

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Equality, Inclusion, and Diversity in Healthcare During the COVID-19 Pandemic

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To the editor,


Public health is a complicated issue. This has become particularly evident during this worldwide pandemic of COVID-19. On May 25, 2020, Mr. George Floyd, an African American man residing in Minneapolis was killed in police custody. For 8 minutes and 46 seconds, the arresting officer had his knee pressed on Mr. Floyd's neck, ultimately killing him through asphyxiation. This event ignited a movement of fiery protests fueled by the current status of racial discrimination and socioeconomic and healthcare disparities in America, much of which is still ongoing as I write this letter on June 2, 2020.

There is mounting evidence that suggests that minorities experience a greater incidence and worse cases of diseases compared to white Americans. The root causes of these health disparities have been heavily studied; racism and discrimination make access to healthcare resources difficult and, sometimes, impossible. When it comes to COVID-19, key risk factors, such as age, sex, and comorbidities (i.e., hypertension, diabetes, and cardiovascular disease), are linked to worse outcomes. Unfortunately, these factors are compounded with the disparities noted with race and socioeconomic status. Poorer communities and people of color experience limited access to health education, hygiene management, and healthy foods. Additionally, they live in areas with denser populations, which makes it difficult to maintain appropriate social distancing, specifically regarding COVID-19.

What Does Research Data Tell Us So Far?

More and more studies continue to demonstrate the disproportionately negative impact that COVID-19 has on African Americans [1]. Overall, black Americans have higher rates of infection and mortality. In Chicago, where African Americans make up only 30% of the population, more than 50% of COVID-19 cases and nearly 70% of deaths were African Americans [2]. In Louisiana, African Americans make up approximately 30% of the population; however, over 70.5% of COVID-19 deaths have been in African Americans [3]. This alarming disparity in numbers was similar in the state of Michigan, where African Americans make up only 14% of the population [4]. Recent data from 1,052 confirmed COVID-19 cases in Northern California showed that African Americans were 2.7 times more likely to be hospitalized than non-Hispanic whites [5]. In Los Angeles County, the average death rate from COVID-19 was estimated to be 9 per 100,000 cases. However, when accounting for race, the African American population had a death rate of 16 per 100,000. Shockingly, in denser black communities, such as West Rancho Dominguez, this rate shot up to 74 deaths per 100,000 cases.

Serious health disparities have also been noted in the Asian American communities, where COVID-19 has additionally contributed to a rise in anti-Asian sentiment, discrimination, and hate-related crimes [6]. Studies found a positive correlation between the percentage of Asian Americans and the percentage of incidence ($r=0.185$, $P<0.0001$) and death ($r=0.211$,

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$P < 0.0001$) from COVID-19 [7]. Data published on *Wellcome Open Research* analyzed the national health records of 16,272 COVID-19 patients in the United Kingdom suggested that black and Asian patients were at higher risk of death from COVID-19 compared to Caucasians.

In early May 2020, the U.S. Food and Drug Administration allowed the biotechnology firm, Moderna, to initiate an mRNA-1273-based phase II clinical trial. Several potential drugs for COVID-19 treatment and vaccination are being tested in numerous large clinical trials around the world. To minimize the health disparity from COVID-19, these clinical trials must include people from all ethnic and racial groups. Otherwise, we will see another level of repetitive health disparity issues from COVID-19 in future treatments and vaccines.

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